Eastern Health Collaborative (RC)

7/13/2017
12:00pm-1:30pm
EIPH Conference Room

ATTENDEES: Janae Larson, Jaylee Packer, Alisha Tueller, Lyndsey Floyd, Amy Myler, Ashlee Carlson, Dr. Boyd Southwick, Eric Gravatt, Natalee Snarr, Dr. Kelly Anderson, Bryce Bond, Steve Hickman, Karl Winegar, Daynah Oryang, Dr. George Groberg, Geri Rackow James Corbett, Corinne Bird, Nicole Foster, Pam Rich, Susan Beckstead, Molly Volk, Chelsey Stevenson, Laurel Ricks, Amanda Birch, Julie Woolstenhulme

WELCOME BY: Dr. Boyd Southwick at 12:05

MINUTES

AGENDA ITEM:	Successful Communication PDSA
PRESENTER:	Eric Gravatt and Natalee Snarr (The Pediatric Center)

DISCUSSION:

Through a PDSA cycle, the Pediatric Center has created an education plan, or their clinic's plan to keep all the staff members aware of the PCMH changes that are occurring in their clinic. They meet weekly as a PCMH transformation team. This team consist of their physician champion, administrator, operations manager, one physician assistant, care coordinator and a nurse. These weekly meeting help them hold each other accountable to assigned tasks and ensure that PCMH work continues to move forward. It's helpful that there is a set time and place for these meetings. The Pediatric Center has noticed when meetings aren't held, there is a breakdown in communication.

The Pediatric Center holds a monthly staff meeting. During these meetings the staff is updated on current PCMH topics, goals and new policies. This gives the staff an opportunity to discuss the changes and ask questions they might have regarding those changes. Every member of the PCMH transformation team takes turns presenting so information comes from their peers and not only from management. In the weekly meetings, these presentation are discussed as well as questions the staff members might have so that they are ready to answer those questions. The clinic works hard to give the staff members ownership of the changes and their work.

In both clinics they have a bulletin board in the breakroom. Their care coordinator created a race track and uses cars to represent the six NCQA standards/concepts. As the clinic progresses towards recognition the cars also progress toward the finish line. This a fun way to help the staff members know the clinic's progress. The care coordinator also posts changes in polices on the bulletin board.

The nurse who attends the PCMH team meetings is responsible for the monthly newsletter. The newsletter contains information from their monthly staff meeting, PCMH or NCQA update, employee spotlights, and other information related to their clinic. Their clinic also uses interoffice messages via their EHR to give updates as needed.

Dr. Anderson, their physician champion attends the weekly meeting. He also takes time in the business meetings with the providers (held twice a month) to give updates and introduce new things the clinic will be doing. He gives a provider's prospective when discussing NCQA guidelines. Dr. Anderson takes times to talk with each provider about changes what are occurring in the clinic. Dr. Anderson takes the opportunity to engage each provider individually and allows the providers an opportunity to talk one on one about concerns or questions they might have.

The Pediatric Center gives employees opportunities to shine. They have a box labeled "you got caught transforming". When someone is observed doing something great related to PCMH, a new policy or change, the person who observes the other employee can write down the action and person's name. The employees who "get caught" receive a little treat and recognition at the monthly staff meeting.

When new employees are hired they are taught about the PCMH education plan as part of their training.

Agenda Item:	PCMH Transformation and Recognition
Presenter:	Dr. Southwick and Ashlee Carlson (Family First Medical Center)

Discussion:

In the beginning of this year Family First Medical Center received PCMH 2014 Level 3 recognition. When starting their transformation process, they were very concerned about maintaining that change and recognition once it was achieved. They realize it's a continuous process. They started the process with delegating more roles and responsibilities to the nursing staff. They soon realized it would run more smoothly if that was someone's dedicated role. Ashlee was then hired as their care coordinator. They created a PCMH team (one provider, one nurse and one receptionist). They would decide what change they needed to implement, and the pilot team would try it out first. This helped them work out some of the problems before implementing it clinic wide. When making changes within the clinic's workflow they focused on little changes at a time. Once the staff adjusted to that change, they would make another change. This time varied from every few weeks to every few months depending on how large the change was to workflow.

Some of the lesson's they learned along the way include: It's very important to have a physician champion. This doesn't mean there won't be push back but it moves the transformation. The responsibilities need to be shared. The nurses felt like they didn't have enough time to do everything they need to do without getting behind. Ashlee helped work through that. Some of the receptionist didn't feel like they had enough education about some of the changes and handouts. Ashlee just took more time to education the front desk staff.

Family First collects social determinate information. The receptionist hands out a form for the patient to fill out. The form is then scanned in and then Ashlee inputs the information into a template in their chart. This form is given to all patients annually. At the end of the form there is a spot for the patient to add anything else they may have concerns about. This has allowed their practice to see and fill needs that may have not come to light without this form.

To prevent PCMH transformation burn-out, Ashlee would break up her work and try not to work on one thing for too long. She also tried to not bite off too much at a time or to do a project too quickly. They realized that true change took time and that they might not get it right the first time. It was a continuous quality improvement cycle.

Patient education was incorporated to their practice. They created a PCMH brochure to help patients understand the changes that were taking place. The providers would also take opportunities educate the patients about their role in PCMH and how a Medical Home works.

Now that Family First is a NCQA recognized clinic, they are working to sustain that change. They continue to pull quality metrics to see how their clinic is doing and if there are areas for improvement. They continue to meet regularly at a quality improvement team. They realize this isn't the end and so they will continue to evolve.

Agenda Item:	State Evaluation Team
Presenter:	Molly Volk

Discussion:

Molly is from the SHIP evaluation team. She is assigned to our region to capture feedback from the patients and clinics of how PCHM is helping them. She hopes to collect success stories. She will be contacting clinics and setting up visits with them. She is starting with Cohort 1 clinics first and then working with Cohort 2 clinics.

Agenda Item:	Child Protective Services
Presenter:	Susan Beckstead

Discussion:

There are around 300 reports from our region to CPS monthly, 60-100 of those reported are followed up on. The rest that are reported aren't in the scope of CPS work. CPS can only take action with legal parents of the child. The reports are divided into priority I-III.

Priority I: When the child is in immediate danger, example: death of a child, safety threat involving physical harm due to mental illness, life threatening physical abuse (child under 6 years old and mark is left), life threatening medical neglect, infant or mother testing positive for an illegal drug or alcohol, withhold medical treatment with a life threatening condition, etc.

Priority II: When child is not in immediate danger but abuse or serious physical or medical neglect, example: non-life threatening physical abuse child is over 6 years older), non-life threatening physical or medical neglect sexual abuse, disabilities, etc.

Priority III: Child is not in immediate danger but abuse or neglect is clear as a result of parents or caregivers. Examples: inadequate supervision, home health and safety, moderate medical neglect, court ordered investigations, educational neglect, etc.

Other circumstances: CPS can't take action regarding children abusing children. They are responsible to education the parents and see what course of action they take to protect the child being abused. When a parent is using drugs, CPS can't always act. If the child is in immediate danger or has access to drugs they can but if drug use is hidden or out of the reach of children, CPS can't do anything.

CPS will send a letter within 30 days of report. If you don't get a letter within 30 days there is mostly more investigation taking place. The letter will not say the patient's name, only the date the report was made to CPS.

Other suggestions: When in doubt, report. If you're not sure if it's something CPS can do something about, report anyways. Some cases are investigated because of the large number of reports that are reported for that case. Notify CPS and authorizes. Emotional abuse isn't recognized as abuse in Idaho.

Agenda Item:	Prescription Drug Monitoring
Presenter:	Pam Rich

Discussion:

Pam reviewed the CDC guidelines on opioid prescribing for chronic pain. There are 12 recommendations to reduce opioid dependence or misuse. For more information see attached slideshow or contact Pam Rich at prich@eiphi.idaho.gov or 208-533-3157.

Other Business and Future Agenda Items:

Complete the Post Regional Collaborative Surveys

Next Meeting

Date: 10/12/2017
Time: 12:00pm-1:30pm
Location: EIPH Conference Room